The Role of Nongovernmental Organizations in the Health Sector of the Philippines

MA. CONCEPCION P. ALFILER*

In response to the pressing needs of the poverty stricken individuals and areas, nongovernmental organizations (NGOs) and private voluntary organizations (PVOs) have launched their own community-based health programs many years before the primary health care approach was formally adopted by the Philippine government in 1979. Some NGOs and PVOs initially extended medical services to the poor who can hardly afford the prohibitive costs of medical treatment. After working in several communities, a number of NGOs realized that providing doleouts did not solve the persistent problems caused by the lack of medical professionals in the rural areas. Thus began efforts at self-reliance in responding to the health needs of the communities concerned which meant going into community organizing and venturing into health financing schemes. This paved the way for the growing importance of the role of NGOs and PVOs in the health sector.

Introduction

Like most developing countries, the Philippines is confronted with the perennial dilemma of how to service the needs of an increasing population with very real resource limitations. These constraints however have not diminished in any way the commitment to health for all. By adopting innovative approaches, there are means by which national health goals can be achieved within what countries can realistically afford. The Philippines continues to aspire for this goal as it searches deeper and deeper to mobilize the resources to support its efforts.

Nongovernmental and private voluntary organizations (NGOs and PVOs) figure prominently in the health scene in the Philippines. Their humanitarian concerns have drawn them to depressed communities who have little or virtually no access to public health services. Responding to the

* Associate Professor, College of Public Administration, University of the Philippines. We are grateful to Ms. Rose R. Cordero for her highly competent research assistance in the preparation of this paper.

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pressing needs of poverty stricken individuals and areas, pioneering Philippine doctors, church and academic-based nongovernmental organizations and some provincial officials of the Ministry of Health, have launched their own community-based health programmes, embodying the principles of primary health care, many years before this approach was formally adopted by the Philippine government in 1979 and implemented nationwide in 1981.[1]

Thus, by the time the government implemented primary health care across the country, a number of rural communities with community-based health programmes already had local health teams and village health workers who had undergone training on preventive health care, common diseases in the community and in community organizing processes. These village health workers not only appreciated the value of indigenous ways of caring for the sick but were also sensitive to the demands of local culture and the economic realities that prevail in their communities.

The Structure of the Paper

This paper will examine a new and lesser known dimension in NGOs' and PVOs' involvement in health activities — the financing aspect. It will attempt to describe the role and responsibility of these organizations in financing health activities by: (1) reviewing accounts of NGO/PVO experiences in health in general and in health financing in particular and (2) documenting health financing schemes of selected NGOs which operate in certain parts of the country paying particular attention to (a) the kind and amount of resources mobilized, (b) the mechanisms for managing these resources and (c) the problems and issues that the administration of these schemes raise.

This paper consists of four parts. The first briefly describes the methodology for gathering data for the study. The second discusses the increasing presence of nongovernmental and private voluntary organizations in health and other social development activities in the Philippines, their role and relationship with government. The third part focuses on three small cases which describe in some detail the health financing schemes of existing programmes of NGOs. The final section of the paper will attempt to summarize the insights and implication of the nature of the financing schemes described and the role of NGOs in financing the delivery of health services.

Methodology

Primary and secondary data for this study were collected from a number of sources: published materials, documents and project proposals, and interviews with knowledgeable individuals, Ministry of Health personnel and key administrators of NGOs whose financing schemes are discussed in the third section of this paper.

Funds mobilized by NGOs are essentially of two kinds. The first are funds to finance day-to-day operations (maintenance costs) plus money provided to enable them to conduct particular activities which particular donors favor (time-bound grants). The second are the funds generated by the people in communities where NGOs have organized community or clinic/hospital-based programmes in health.

Both types of resources are the concern of this paper. But time constraints and the reluctance of some NGOs to disclose these aspects of their operations kept us from acquiring substantial information on the first kind of resources. Moreover, we chose to spend time seeking out NGOs whose programmes had some form of a local health financing scheme incorporated in it.

The choice of NGO programmes whose financing schemes are documented for this paper was prompted essentially by one major criterion: Does the programme have any mechanism for raising funds to support health services? The state of information on NGOs in the Philippines is still such that there is no ready source of information on the nature of the programmes they undertake and much less on the financing aspects of these programmes. For this reason, we spent some time identifying health programmes with some health financing schemes. We were thus glad to know of the schemes incorporated in the three programmes we have chosen to discuss. It must be stressed that these programmes are only illustrative of some financing mechanisms that NGOs utilize at the moment. The absence of any systematic and organized information source prevented us from determining the possible universe of this study. It is possible that some NGOs may have projects which use other means of providing financial support for health services which are not documented in this study.

How does this report define its two central concepts: nongovernmental organizations and health financing? *Health financing* will be used to refer to the "raising of resources to support or pay for goods and services" to meet preventive, promotive and curative health needs of individuals and of a community. This definition covers community financing of primary health care — the mobilization of resources by a community to support, in part or in full, basic preventive and curative health services for its members.[2]

Nongovernmental or private voluntary organizations refer to nonprofit and voluntary agencies which are formally structured, i.e., have a legal existence, with an operating system and whose aims are essentially those of promoting humanitarian concerns.[3] NGOs and PVOs tend to focus their services on marginal groups such as farmers, fishermen, squatters, women, tribal minorities and youth. They likewise emphasize the setting up of people's organizations, and promote self-reliance and participation among their target groups. [4]

The Role of Nongovernmental Organizations in Health

The phenomenal growth of NGOs involved in health and health-related activities in the Philippines is clearly manifested in such indicators as (a) the marked increase in their number as suggested by the publication of a number of directories of NGOs and (b) the growing literature produced on their activities.

A seminal study on the country's rural health care delivery system in 1978 identified about 98 community-based health programmes operated in various parts of the country by church-based nongovernmental organizations, private voluntary organizations, educational institutions and the government.[5] By October 1983, the Philippine Business for Social Progress had produced for the Ministry of Health, a directory of NGOs in health which listed some 204.[6] In 1982, the Ministry of Health itself conducted a survey of NGOs in primary health care and identified some 331 organizations.[7] Of this number, however, only 77 responded to the questionnaire distributed for the survey.

In 1985, the Philippine Partnership for the Development of Human Resources in Rural Areas (PhilDHRRA), a national network of nongovernmental organizations in rural development work produced its own directory of 88 NGOs in rural development, 45 of which consider health and nutrition as one of their major concerns.[8] Culling data in this direcotry, CENDRRHA's *Development Memo* described these 88 NGOs in the following terms:

(a) Mostly young organizations founded after martial law was declared in 1972, although a few started early as the 1950s.

(b) They are generally of two types: (1) community-based NGOs which provide direct assistance to the target groups, and (2) servicing NGOs that do not engage in direct organizing work but provide specific services such as training, research or agricultural extension services.

(c) Community-based NGOs' operations are usually limited. Most of them cover less than ten non-contiguous villages located in different regions and provinces.

(d) Staff-size is small, averaging between 10-20 staff members. There are usually salaried staff but some have a mixed complement of salaried staff and volunteers.

(e) NGO's services are either given free or subject to low charges. For their resources, NGOs tend to rely on local and foreign funding agencies for operational and maintenance needs.[9]

This characterization parallels the findings of the 1983 Ministry of Health (MOH) survey of NGOs in primary health care.[10] This survey showed that among the 77 respondent NGOs, 36% were established between 1973 and 1978 while some 15 (20%) had been in existence for more than 20 years. Some 42% of the respondents indicated that their staff size ranged from one to ten personnel.[11] The MOH survey disclosed that NGOs relied on donations/gifts/sponsorships/grants for their main source of funds. Aside from these, some rely on investments, income-generating projects, endowment funds and assistance from other government/foreign funds.

Questions on their net assets revealed a broad range from ₱100,000.00 to ₱5,000,000.00 with 26% at ₱100,000.00 and a further 26% with the range ₱1,000,000.00 to ₱5,000,000.00 A little over a fifth (22%) set their assets as between ₱100,000.00 to ₱500,000.00. Some 9 respondents assessed their assets as falling in the ₱100,000–₱500,000 bracket while 8 (12%) indicated that their net assets would be at the ₱5,000,000.00 level.[12]

What do these NGOs usually provide for their clients? More than half of the NGOs (58%) claim that they provide both services and funds, 17 (25%) say that they provide funds only, while 16% answered that they provide services alone. On the nature of services they support financially, 75% indicated that they fund technical assistance, over 40% fund logistics, 35% provide funds for drugs and some 31% fund income-generating projects. A fifth provide funds for infrastructure projects and for the distribution of relief.[13]

Only 40 NGOs estimated the percentage of their total budget allotted for health activities in 1982. Some 28% claimed that 51-75% of the total budget was used for health projects. A smaller group (15%) set aside more than 75% of their budget for health activities alone, while 22% allotted less than 10% of their total budget for health.[14] Considering the wide ranging financial bases of the NGOs covered by the survey, the percentage of their budget allotted for health may be misleading unless related to the size of their annual budget.

Respondent NGOs' involvement in health activities were classified broadly into four categories: health service, health research and development, the production of health materials and health manpower development. Allowing for multiple responses to these questions, health services and health manpower development received the highest responses. Of those who are in health manpower development, more than half were training health professionals and auxiliaries while only six focused solely on health auxiliaries. The particular health services rendered were as follows: health education (79%), maternal and child health (74%), family planning (64%), immunization (47%), treatment of common disease and injuries (64%), promotion

of proper nutrition (59%), prevention of locally endemic disease (51%), provision of medical drugs (46%) and adequate supply of safe water and sanitation (39%). Of the remaining activities, the most popular were education and community organization.[15]

Households in the lower economic classes are the main target clientele of almost all of the NGOs although a majority of them also view the middle classes as part of their clientele group. A third of the NGOs service migrants and about the same number care for cultural communities.[16]

When asked to assess their strengths as organizations, the NGOs considered themselves proficient in training (65%), service delivery (61%), research (54%), use of innovative techniques and activities (24%) and production of information and educational campaign materials (11%). On their perceived areas for improvement or assistance, 43% cited problems in administering projects, particularly with regard to financing, fund-raising and logistics.[17]

A review of Philipppine researches and experiences on primary health care and related approaches showed that NGOs have produced considerable materials for the training of community health workers and for organizing and implementing community-based health programmes.[18] Personal accounts of medical practitioners, community organizers, nurses and other personnel in these programmes offer another rich source of insights. NGOs' experiences and learning in the processes of organizing, training, deploying community health workers, and in getting the community to assume more responsibility for carrying out the programmes themselves were considered valuable inputs into the evolution of the government's strategy as the latter launched a nationwide primary health care programme.

To share learnings in this field, dialogues between NGOs and government representatives have been deemed necessary. But for some reasons, this proposed coming together did not materialize as easily as expected. A strained relationship emerged between NGOs and government. There seemed to be a mutual distrust caused largely by differences in NGOs and government's assumptions and approaches in their methods of delivering social services and a lack of appreciation of each other's policies, intentions and long run plans and responsibilities.

One of the sources of tension between government and some NGOs is the assumptions made by the latter about community organization processes. Some NGOs explain poverty in rural communities as a manifestation of the people's sense of powerlessness. To counter this deprivation, people must therefore empower themselves through collective action, setting up people's organizations which they must manage themselves.

This philosophy of organizing is held suspect by some government sectors since it may imbue communities with a more politicized view of their environment and may cause them to regard government in a negative light. It must be stressed though that government does not mistrust all NGOs nor do all NGOs refuse to work with government. A few NGOs do support government and some cooperate with the latter on a case-to-case basis.

Despite these difficulties, the strengths of NGOs as alternative ways of extending social services like health to depressed communities are well known. Foremost among their sources of organizational strength are their (a) capacity to respond quickly to unmet critical needs of disadvantaged populations in any part of the country, (b) their flexibility, innovativeness and sense of purpose which emanates from their relative autonomy and freedom from formal control, and (c) their access to external financial and material resources which can be efficiently managed in small organizations.[19]

In her assessment of NGOs implementing primary health care programmes in the Philippines, Cariño cites at least four clear advantages of NGOs over governmental units. First, their community-tailored activities provide them a greater potential for responsiveness to peculiar community needs. Secondly, they have committed staff who find in the programme an outlet for their missionary zeal. Thirdly, they are freer not only to make innovations in their approaches but also in their analyses of how the greater social structure affects people's living conditions. Finally, their holistic approach which is strongly process-oriented puts less pressure on them to show results and puts them in a better position to undertake preventive and promotive health care, while also attending to curative needs.[20]

Nongovernmental organizations also have their own share of weaknesses which Cariño identifies: their concern for process tends to make them underestimate the value of indicators or targets; in their desire to be truly responsive to immediate community needs, health can take a backseat to other demands; there is a tendency for strong personalities to prevail even over supposed collegial and democratic structures of NGOs. While they have proven effectiveness and sustainability over time, their efforts and effects tend to be confined to small areas.[21]

NGOs need to work out how they can best relate with government without sacrificing their flexibility. The partnership that must be achieved is still to be forged. Happily, a closer working relationship may now be achieved in view of the Ministry of Health's attempt to involve NGOs in their investigative task forces as well as in their Coordinating Council for Health Concerns through which the cooperative efforts of public, private and nongovernmental organizations in health are to be coordinated.[22]

Three Examples of Health Financing Schemes

While the literature on NGOs' involvement in health service delivery has grown considerably, much of it discusses the processes of organizing and training community health workers and the complex social dilemmas confronting medical professionals as they work under conditions of scarcity in depressed communities. Very little of the literature, if any at all, documents particular financing schemes developed to support health services provided to the community. This may simply be because few such schemes exist.

The three schemes which we have documented are essentially income-generating projects with part of the income set aside to support community health services. They are based on the view that poverty underlies most of the health problems in depressed areas. Thus poverty alleviation through income-generating projects is seen as a logical component of health intervention. For instance, the UNICEF's income-generating projects designed for poor families with children exhibiting health and nutritional deficiencies would fall under this category. One of the 13 UNICEF-assisted nutrition and nutrition-related projects with built-in income generating components is the Loan Assistance Programme being carried out by AKAP, a non-governmental organization which implements urban and primary health care programmes and trains health professionals to engage in community-based health activities in poverty stricken areas. AKAP's Loan Assistance Programmes provides community health workers/volunteers with seed money for small family business such as managing a general store, food hawking, bag making or a simple "buy and sell" effort. AKAP's medical staff who work with these health workers supervise and monitor these economic activities.[23]

*The Institute of Primary Health Care's (IPHC) Community Capability Building Project**

The Institute of Primary Health Care of the Davao Medical School Foundation (DMSF) is internationally known for its Katiwala project. The word "Katiwala" is derived from the Filipino word "tiwala" which means trust. As originally conceived, the Katiwala programme was basically a health intervention programme that sought to establish a continuing mechanism for primary health care in the community through four specific activities: (a) the training of community-selected and community-based health workers in curative, preventive and promotive aspects of health care; (b) the dissemination of health and nutrition information to the community through mothers' or family classes; (c) the continuous identification of the community's changing needs and the mobilization of local

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resources for meeting these needs; and (d) the determination of local social services which are not utilized by the community because of its unawareness of the availability of these services.[24]

From its origins as a free medical clinic in 1967, this programme has gone through four stages. In the first stage, from 1967-1972, it offered free or partly subsidized medical services to the urban poor in the city of Davao, Mindanao. On realizing the negative effects of doleouts, it decided to train community health workers *(Katiwalas)* (1972-1976). In its third stage, 1976-1979, it saw the value of community organizations and started its rural outreach effort. It was during this stage, that the Davao Medical School Foundation was formed through an ecumenical consortium of two academic institutions, two hospitals and the Development of People's Foundation (DPF) which was conducting training for the Katiwalas. The Katiwala programme of the DPF became the responsibility of the Institute of Primary Health Care (IPHC) which became one of the four operating units of the Davao Medical School Foundation. At this stage, the IPHC strengthened the community organization component of the Katiwala training programme and established linkages with government offices through the intervention of a specialized international agency. From this stage the programme moved on to its fourth stage, the community building stage where it chose to go beyond the concern of health in its community efforts. This decision was prompted by the realization that regardless of its interventions, the social problems which the programme sought to address continued to persist. The programme staff discerned that the basic economic difficulties confronting the communities continued to reverse advances achieved in other fields.[25]

Since 1980, the IPHC has widened the ambit of its concern to other community activities such as training of farmers in basic farm management, conducting continuing education sessions for livelihood programmes with topics such as feasibility studies for small business and simplified book-keeping. Idle mothers and community residents who showed interests in acquiring skills were trained and given the initial capital necessary to start a small business under a small handicraft programme. As it ventured into other fields, the programme gradually transferred health care responsibilities to the individual families under the home-based health record system which was introduced by the Katiwalas.[26]

The IPHC community capability building activities include family and community dialogues where aspirations are presented and barriers to these aspirations are determined by the group. Common aspirations included sending their children to school, eating three meals a day and increasing income. Since a basic barrier to their aspirations is the lack of income-producing opportunities, income-generating projects which the community

can undertake are identified and financial assistance is given through community credit groups.

There are two types of community credit groups: those formed by urban families and those composed of members from rural households. A credit group may consist of 5 to 19 members. Each group formulates its own rules and agreement as to how it will lend to members and for what activities. In 1984, there were 8 credit groups with a revolving fund of ₱1,000 to ₱1,450 to lend to its members. By 1986, there were 26 such groups with an average lending base of ₱1,500 and a total of 241 community members using the financial assistance extended by the community credit groups.[27] Members can borrow a minimum of ₱200 and a maximum of ₱400 for such family enterprises as dressmaking, tailoring, the purchase and sale of fruits and other foodstuffs and the selling of native delicacies. They charge a 10% interest on loans given to members.

Out of the earnings of the fund, the group sets aside ₱5.00 per day from the net profit for a community health fund. Apart from this amount, the community credit group members pay monthly dues of ₱5.00 per member for an emergency fund. The community health fund may be used for health needs which the group determine for themselves. This may include provision of water, procurement of water-sealed toilets and provision of dental and medical care.

A rural credit group composed of farmers, on the other hand, applied for a loan of ₱11,000 from the IPHC to match ₱5,000 of their own funds for the purchase of a second-hand corn mill. The IPHC loan is to be repaid within 2 years with an interest of 5% per annum. A social development fund will be established from 5% of the net income of the corn mill plus the 5% interest for the loan from the IPHC. This social development fund may be used for such needs as the construction and repair of a water system for the community, improving existing vegetable gardens, or to finance part of the training costs for volunteers such as the Katiwalas. Support for part of the training costs may come in the form of paying for half of the cost of board and lodging and transportation expenses. After two years, it is expected that the proceeds of the fund will be sufficient to finance fully the continuing education of volunteer leaders in the village.

The IPHC helps the community groups in organizing the structures and the system necessary to enable them to manage the projects efficiently. It also helps them to consider means through which the group can help the larger community in meeting its health needs.

Among the problems noted in the operation of the community credit groups are: (1) the difficulty of scheduling meetings which members can

attend regularly, (2) members who are used to doleouts lose interest once they realize that they must work for their share, (3) improper use of funds by a member, and (4) lack of peace and order in the village may make it difficult for the IPHC staff to monitor some areas.

*The UP-IPH/SEAMEO/FRG/GTZ Community Health Development Project**

This is a multilateral project involving the University of the Philippines Institute of Public Health (UP-IPH), the Southeast Asia Ministry of Education Organization (SEAMEO) and the Federal Republic of Germany (FRG) through the German Agency for Technical Cooperation (GTZ). This project commenced in 1982 when the UP-IPH faculty, with some hesitation, agreed to manage a 90,000 deutsche mark grant (equivalent to about ₱450,000 then) from the Federal Republic of Germany to be utilized as a revolving fund in upgrading community health services through community self-help projects.[28]

To ensure the operations of a "revolving fund", the grant is to provide seed money to community projects whose loan amortization, after a certain period, is passed on to another project, thus enabling the fund to service a bigger population.

Six criteria have been established for the selection of community self-help projects to be funded by this grant. These are:

(1) The project should directly contribute to community health financing by allocating a specified proportion of theproject and net income for primary health care;

(2) The group must have existed for some time and show some achievement;

(3) The project must be endorsed by the Association of Barangay Captains (village chairmen);

(4) Projects should not duplicate existing projects unless there is a demand for the service/ product;

(5) Projects should benefit a large number of people;

(6) There must be evidence of a market for the product.[29]

A loan proposal must be submitted for screening. This proposal must detail the justification for the project in terms of the barangay/municipality needs, its expected outcome, specific activities planned, how the project is to be organized and monitored, plus the resources that will be required from the project funds, from the proponents themselves, and from other parties.

*We gratefully acknowledge the time shared with us by Dr. Teodora Tiglao and Ms. Elnora Duque of UP-IPH for our interviews with them on this project.

This loan proposal goes through three screening levels: (1) at the local rural health unit, (2) the provincial/city health offices and (3) the UP-IPH. At the local rural health unit, the relevance of the project to community needs is considered and approval is obtained from the barangay officials. The provincial/city health officers, who help supervise the project once approved, likewise assess the merits of the proposal. Finally at the UP-IPH, the Executive Committee of the Department of Public Health Administration, the faculty perceptor who supervises UP-IPH students who study in the community, and the German consultant of the project, deliberate on the proposal with the Executive Committee taking the final decision whether to grant the loan or not.[30]

Once approved, the contract is signed by the project proponent together with the Provincial or City Health Officers who assume responsibility for supervising the project jointly with the UP-IPH. Monitoring of project implementation and loan repayment schemes are spelled out in the contract.

The interest charged on all loans regardless of the period of maturity is 15% which goes to the community's Primary Health Care Committee (PHCC) to be spent solely for health development of the municipality/barangay. To ensure proper handling of funds, proponents are asked to maintain a separate bank account for their project. Moreover, project proponents are asked to submit a quarterly financial report with supporting documents such as receipts. At the UP-IPH end, an accountant serves to keep the books for the whole project.

The monitoring structure at the UP-IPH consists mainly of the project team leader who prepares the comprehensive project report based on field reports submitted by the field director, the faculty preceptor and a research assistant assigned to the project site. The field director and the faculty preceptor visit the project site at least once a month, with the research assistant taking care of the day-to-day monitoring of the self-help project by collecting reports and data such as bank and financial statements, receipts and progress and financial reports from the project proponents. In collaboration with the municipal health officer of the area, the faculty preceptor prepares a field report. The data collected by the research assistant and the faculty preceptor's report are submitted to the team leader through the field director and the chairman of the Department of Public Health Administration. These form the bases of the team leader's comprehensive report to the Executive Committee of the UP-IPH Department of Public Health Administration.

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The Community Self-Help Projects. The UP-IPH/SEAMEO/FRG/GTZ Community Health Development Project has approved a total of seven community self-help projects. These projects are carried out in one urban community and six rural municipalities. To protect the identity of the communities where these projects are undertaken, this paper will refer to these areas by numerals. These projects are:

1. A swine raising project of the "B" Health Development Inc. (BHDI) located in a depressed urban area in Manila with a loan of ₱25,000;

2. A cattle fattening, fertilizer and swine raising project of the "M" Primary Health Care Committee (BPHCC) in municipality 1 with a loan of ₱60,000;

3. The water supply development project of the local government, Rural Waterworks Development Corporation (RWDC) and the "K" Rural Waterworks Association (KRWA) in municipality 2 with a loan of ₱140,000;

4. A plant nursery project of the Kabataang Barangay (a village youth organization) in municipality 3 with a loan of ₱5,000;

5. Another cattle fattening project of the "P" BHPCC in municipality 4 with a loan of ₱60,000;

6. The rent-a-farm machinery project of the "MM" BPHCC in municipality 5 with a loan of ₱75,000, and

7. A hollow blocks making project in "BU" BPHCC in municipality 6 with a loan of ₱50,000.

Of these seven projects, only those which have been functioning for at least one year will be briefly discussed in this paper.

The *Swine Raising Project in an Urban Area in Manila.* The BHDI is a non-stock, non-profit and non-sectarian organization which holds office at the *Bagong Lipunan* (New Society) Health Center of a depressed urban area in Manila. It was organized as a consequence of the joint efforts of the UP-IPH and the Manila Health Department. Among its specific purposes, the BHDI's article of incorporation states the following:

1. To foster health development and promote community competence;

2. To unite and close all the ranks of the community leaders and the barangay official together with the health officers in the area;

3. To assist in planning and organizing community-based solutions to health and other problems, and

4. To assist in strengthening of basic health services being rendered in the community...[31]

The members of this nongovernmental organization are residents of three depressed urban barangays and some 26 clubs, associations and organizations operating in these areas. Each of these three barangays are represented by the barangay chairmen and one barangay official designated by the chairmen for this purpose. The 26 different clubs, associations and organizations on the other hand are linked to the BHDI through two representatives, the club's president and one other official.

The decision to undertake the swine raising project was triggered by the construction of a mini-medical laboratory in the community in 1984. Funded through a ₱28,000 German grant, the mini-laboratory was set up on the condition that the residents will help maintain its operations.

Since the income of the majority of the households in the community was below the poverty line, they could not afford to financially support the maintenance of the mini-laboratory. Thus, BHDI decided to engage in a swine raising project "... for the low income families in the community ... to improve their lot and their standard of living that they can help in the development of the community."[32]

The project proposal required a loan of ₱25,000 to finance its initial investment. This loan was approved and released by BHDI by early January 1985 and 48 piglets were bought at a cost of ₱24,000. The project was not initially able to set aside 10% (the earlier interest rate set, later raised to 15%) of the loan intended for the local primary health care committee. This was accepted by the UP-IPH so that the initial implementation of the programme would proceed smoothly.[33] To manage the project, BHDI constituted a five person livelihood committee which was to supervise the project and to submit periodic reports to the BHDI on the project's progress.

The Cattle Fattening, Fertilizer and Swine Raising Project of the BPHCC in Municipality "1". The site of this project is a rural village with coffee, banana and papaya as its primary crops. To supplement income from these agricultural crops, residents also engaged in livestock and poultry raising. Its low annual income of ₱8,000 (approximately $400) per household renders its residents easy prey of usurious lenders in the community.

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The Barangay Primary Health Care Committee applied for a loan of ₱140,000 but only ₱60,000 was formally awarded. By March 1985, 6 qualified beneficiaries had received cattle fattening loans of ₱6,000 each, while eight farmers received loans for the purchase of fertilizers.

The project functions like a mini-bank in the community. Loans are only granted to residents who have proven that they have the capability to pay, have friends or relatives who can serve as co-makers or guarantors and have collaterals which they can offer to secure their loans. The 15% interest is retained by the BPHCC upon release of the loan. Beneficiaries who are not able to make their monthly payment on time must pay a fine of 2% per month. They have nine months within which to pay the loan as the project's UP-IPH loan also matures after nine months.

By December 1985, the project had accumulated a bank balance of ₱69,547.97. Instead of paying up the loan, the PBHCC decided to renew its contact to allow a second phase of the project. Thus, by June 1986, the project had released another set of loans of ₱55,000 for fertilizers and ₱21,000 for swine raising.

The Water Supply Development Project of the Municipal Government, the Rural Waterworks Development Corporation and the "K" Rural Waterworks Association in Municipality 3. A joint undertaking of the municipal government, its local waterworks development corporation (RWDC) and the community's rural waterworks association, this project seeks to provide adequate piped water supply to the residents of three barangays. Work on the project started in February 1985 and was supposed to have been completed by May 1986.

The UP-IPH released ₱140,000.00 to cover the cost of constructing a ground tank which will be connected to a spring box and main pipes to distribute water to the houses in the villages. The community was to provide labor for the construction of this water system. Also, the community was to provide funds to buy pipes which will connect their houses to the main distribution point of the water system. Payments for the loan and funds for primary health care activities were to come from water bills of from ₱8.00 to ₱10.00 per household per month.

Although the ground tank has already been constructed, the project has not been completed since 21 main pipes bought for the project were used by the local waterworks authority for the distribution of water to communities near the spring box and the ground tank. The change of local officials brought about by the February 1986 revolution has complicated this problem further as the local officials who authorized the "borrowing" of the project's 21 pipes are no longer holding public office. Fortunately

for the local waterworks association, the new officer in charge of the municipality pledged support to continue work on the project and to assume responsibility for its completion. This assurance led to the "restructuring" of the loan with the hope that the project will be completed later.

*The LIKAS Cooperative Rice Mill and Store for Community-based People's Health Project**

LIKAS is the acronym for the Filipino words "Lingap para sa kalusugan ng Sambayanan" or "care for the health of the people". It is the health service institution of the Center for Community Services (CCS) of the Ateneo de Manila University, one of the exclusive catholic schools in Manila. Through LIKAS, the CCS implements a people's health programme in the rural areas which emphasizes self-help in medical care and trinas residents on the necessary skills and knowledge they must have to be self-reliant. It engages in education and community organizing activities for the rural poor. It also implements a volunteer programme where health professionals and student volunteers, working with people in rural communities as partners, attempt to resolve health and related problems with the community and eventually develop the latter's capacity to analyse and act on their common problems.[34]

The LIKAS proposal for the setting up of a cooperative rice mill and store to finance a community-based people's health programme is one of the financing schemes to be implemented by a non-governmental organization which was approved by the Philippine Council for Health Research and Development (PCHRD) under the USAID primary health care financing project. The proposal is to pilot the use of a service cooperative model as a practical and sustainable health care financing scheme of a community-based health programme.[35] The scheme calls for the formation of a service cooperative with community health workers and the poorer residents of 19 villages as members, to run a rice mill and to buy and sell palay and rice through the operation of three cooperative stores. This effort will be implemented in 19 depressed communities.

Community health workers in each community are organized into a community health team with a chairman, vice-chairman, secretary, pharmacy aide, auditor and project officer. The volume of resources which these community health teams have generated on their own may be gleaned from the operations of the village pharmacy, the anti-TB club and the community health fund. There are 21 village drugstores which have been capitalized with a supply of generic medicine valued at about ₱500.00 to ₱700.00. Sales in

*We are grateful to Dr. Eddie G. Dorotan, LIKAS Coordinator, and to Ms. Tootsie Herrera of CCS for sharing with us vital information on the operations of this project.

these village pharmacies range from ₱60.00 to ₱200.00 per month. These pharmacies sell their drugs with a 20% mark up with 5% of the profit earned earmarked for the capital fund, 5% for the community health fund, and 10% to the pharmacy aide.

Medication costs for the anti-TB club is shared on a 75-25% basis. The programme shoulders 75% of the cost of the medicine while the patient pays for the remaining 25%. The programme's share is funded through donations, sponsorships and other fund-raising activities such as the holding of cultural plays.

The community health fund was set up through the holding of a raffle and other one shot fund-raising activities. The earnings from these activities were divided equally among the villages. Each community received ₱466.00 for their share. This amount was used as an emergency loan fund which the community health workers themselves manage. Some of the criteria they use in determining who can borrow from the fund are: (1) urgency of need, (2) capacity to pay. In cases where the resident who needs the emergency assistance can afford to pay, they are allowed to borrow without interest. However, if the family in need is in no position to pay back, then the organization may decide not to collect on the loan. In some instances, residents who get cash assistance may pay back in kind.

After three years of operation, LIKAS felt that with the financial assistance coming from private funds, external support from foreign donors, access to government agencies (through the use of public health clinics and hospitals in rural areas) and with the resources which the people themselves generate, the foundation for self-reliance in health care has been laid through the established organization of trained community health workers. What was critical to sustain the momentum of the programme was an economic base which could make it self-reliant financially too.

After two months of deliberation on what the community can do, residents agreed on the formation of the cooperative to operate a rice mill and buy and sell palay and rice through cooperative stores. To finance the setting up of the cooperative, purchase of the rice mill and the capitalization of the cooperative stores, LIKAS requested assistance of ₱2,233,485.84 for a three year programme. Of this amount, about 50% or ₱1,839,503.07 will be released for the first year; ₱187,204.60 for the second year, and the remaining ₱206,778.17 for the last year. For their part, LIKAS and the community will assume responsibility for costs amounting to ₱537,543 to cover office rent and food for trainees for the three year period.[37]

Conclusions

The emergence of these NGOs was a response to the serious inadequacies in the delivery of social services to the poorer sectors of the population.

Unfortunately, this sector is unable to compete in the open market and tends to rely heavily on publicly provided services which are given free. As the inadequacies of free public health services became more telling, NGOs emerged as an alternative means through which life-sustaining services could reach those who otherwise had no easy access to them.

Initially, some NGOs were there merely to extend to the poor the medical services they needed but could not afford to pay for in the market. However, after working in most of these communities, a number of NGOs saw that providing doleouts did not solve the persistent problems caused by the lack of medical professionals in rural areas where most of the people were. As these conditions became apparent, NGOs trained community health workers who were to minister to the needs of the community as far as simple "health services" are concerned. But even this was considered insufficient. In keeping with the call for self-reliance in health and other needs which most of the NGOs sought to instill in the communities, NGOs went into community organizing to encourage the people to take stock of what their common problems are, their resources and what they can do by themselves to confront and resolve these problems. Applied to health needs, this meant that communities must strive to satisfy their needs through ways which are consistent with the economic character of the area. Through the process of community organizing, health professionals and workers promoting the primary health care or community-based approach sought to empower the people to take concrete and concerted action on common health concerns which in the past they were made to feel powerless about. The use of community organization processes unleashed community forces which were untapped before simply because people were not confident that they can modify their wider environment which seems to nurture their poverty and powerlessness.

Aware of the value of a strong and well founded organization in the communities, most NGOs in health devoted much of their time to the refinements and reformulation, where necessary, of community organization processes to ensure that community organization methodology blends well with local culture and serves to enhance the communities' inherent strengths.

It is the contention of this paper that some NGOs in the Philippines have been preoccupied for some time now with their work on the process of community organizing and in continuously seeking more effective ways of institutionalizing participatory mechanisms through which the people can take active parts in their community health programmes. This preoccupation with the communities' needs and conditions enhanced the NGOs' knowledge of the people's aspirations. It also served to reinforce their view that the deeper cause of the communities' recurring health problems is really the low income level which is inadequate even to provide for such basic needs as food and shelter.

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Given the level of poverty prevailing in most communities where NGOs operate, it became even more difficult to plan some kind of prepayment scheme where households could pay to cover the shared or even subsidized costs of medical care. This is because:

1. There is really very little household income for food, let alone for health care.

2. There is a tendency to expect that health care will be provided free by the public health system.

3. "Adequate" health care is pragmatically defined in the communities as having physical and economic access to medical services and drugs when one is ill.

Non-governmental organizations have undoubtedly augmented scarce resources for health by serving as legitimate channels through which foreign and private funds are converted into services delivered to the community.

As the NGOs consciously and deliberately seek for more ways of responding to the needs of the people and the communities and as they move to evolve mechanisms for working closely with various levels of government, there is great hope that health financing schemes most appropriate to and in harmony with the Philippines' local culture and economic realities will evolve and be sustained over time.

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